MDR Tracking Number: M5-04-0478-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 10-15-03. Dates of service 03-20-02 through 09-26-02 were not timely filed per Rule 133.308 (e)(1).

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor $460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The office visits with manipulation, myofascial release, electric stimulation and electric current therapy were found to be medically necessary. The prolonged service/office visit was not found to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to dates of service 01-15-03 through 01-17-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 31st day of December 2003.

Debra L. Hewitt
Medical Dispute Resolution Officer
Medical Review Division
DLH/dlh

December 23, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-0478-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ___ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ___ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a female who sustained a work related injury on ___. The patient reported that while at work she injured her back when she attempted to lift a 35lb. box of detergent off a conveyor belt. The patient underwent an X-Ray of the lower spine on 1/16/02 and 2/27/02, an MRI of the lumbar spine on 2/28/02, EMG/NCV on 2/19/02 and 11/19/02 and fluoroscopic examination on 2/27/02. The diagnoses for this patient have included lumbar strain, low back pain, lumbosacral spondolysis, myalgia and myositis, lumbar spine disc disorder and lumbar spine radiculopathy. Treatment for this patient has included physical therapy consisting of muscle stimulation, cryo therapy, moist heat and myofascial release. The patient has also been treated with an epidural steroid injection performed on 2/27/02 and oral pain medications.

Requested Services

Office visit with manipulation, myofascial release, electric current therapy, electrical stimulation, prolonged service/office from 1/15/03 through 1/20/03.

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is partially overturned.

Rationale/Basis for Decision

The ___ chiropractor reviewer noted that this case concerns a female who sustained a work related injury to her back on ___. The ___ chiropractor reviewer also noted that the diagnoses for this patient have included lumbar strain, low back pain, lumbosacral spondolysis, myalgia and myositis, lumbar spine disc

disorder and lumbar spine radiculpathy. The ___ chiropractor reviewer further noted that treatment for this patient's condition has included physical therapy consisting of muscle stimulation, cryo therapy, moist heat and myofascial release. The ___ chiropractor reviewer indicated that this patient has an internal disc derangement which is a very unstable problem. The ___ chiropractor reviewer explained that the patient obtains relief with treatment and has remained working with restrictions. The ___ chiropractor reviewer noted that the patient experiences periods of extended relief followed by exacerbations.

The ___ chiropractor reviewer explained that this is the nature of her condition and that the patient requires treatment for these periodic exacerbations. The ___ chiropractor reviewer indicated that there is no documentation provided to support an extended visit on 1/20/03. The ___ chiropractor explained that the visit on 1/20/03 was the patient's 3rd visit in 5 days and therefore should be considered a regular visit. Therefore, the ___ chiropractor consultant concluded that the office visit with manipulation, myofascial release, electric current therapy and electrical stimulation from 1/15/03 through 1/20/03 were medically necessary to treat this patient's condition. However, the ___ chiropractor consultant concluded that there is no documentation to support a prolonged service/office on 1/20/03 and that this service was not medically necessary to treat this patient's condition.

Sincerely,